VERIFICATION OF LEGAL LIABILITY FOR APPLICANTS/RECIPIENTS OF PUBLIC ASSISTANCE

To: _____ From: _____
Legally Liable County — Department of Health and Human Services (DHHS) District Office

The person named below is an applicant or recipient of public assistance. Per RSAs 165:1,I, 165:2-a, 166:1-a, 166:8, 166:10, 167:18-a, 167:18-h, it has been determined that the person is the legal liability of your county. Your acceptance of this liability must be recorded in the files of this Department. Please complete, sign, date and return this form **within 10 days** to: DHHS, **Office of Finance, Billing Unit, 129 Pleasant St., Brown Building, Concord, NH 03301-3857.** Failure to return this completed, signed form within 10 days of the date below, indicates your county's refusal to accept legal liability for this person.

_____ _____
Family Services Specialist (FSS) — Date

CLIENT INFORMATION . . . . to be completed by DHHS District Office

Name: _____ Date of Birth: _____

Case #: _____ Medicaid ID Number (MID): _____

Category of Assistance: ☐ OAA cash ☐ OAA Medical ☐ APTD cash ☐ APTD Medical

(There is no county liability for OAA cash or APTD cash, per RSA 167:18-a)

Type of Service: ☐ NF Care ☐ HCBC-CFI/DD/ABD/IHS

☐ Male ☐ Female

Application Date: _____

HISTORY OF RESIDENCE [start with most current residence]

Town/City	Address	County	From	To	TYPE OF HOUSING: Own Home	Relative's Home	Private Rental	Residential Care	Subsidized Sect 8	Nursing Facility	Hospital Swing Bed	Other - Explain

FINANCIAL INFORMATION . . . . to be completed by DHHS District Office

Date that NF/HCBC services will begin: ___/___/___ HH Size:_____

Applicant Spouse?: ☐ Yes ☐ No
If yes, enter applicant spouse data below:

Spouse's Name: _____ ☐ Male ☐ Female DOB: ___/___/___ MID:_____

REPLY . . . . to be completed by County

We ☐ agree ☐ disagree that the individual named above is a liability of: _____ County.

Justification for disagreement: _____

_____

_____

NOTE: If you disagree that your county is legally liable for the individual named above you must submit justification for your denial. Failure to provide this justification for your denial **within 10 days of the date on this form** indicates your county's refusal to accept legal liability for this person. You can state your justification in the space above or attach documentary evidence to this form.

_____ _____ _____
Printed Name and Title of Authorized Official — Date — Telephone Number

_____
Signature of Authorized Official

RETURN TO: Office of Finance Billing Unit, 129 Pleasant St., Brown Building, Concord, NH 03301-3857